Title 15 - Mississippi Department of Health

Part III – Office of Health Protection

Subpart 01 – Health Facilities Licensure and Certification

CHAPTER 52 MINIMUM STANDARDS FOR CHEMICAL DEPENDENCY UNITS

100 INTRODUCTION LEGISLATIVE AUTHORITY

100.01 Mississippi Department of Health Mississippi Code Annotated 43-11-1 through 43-11-27 (Supplement 1986) The Mississippi Health Care Commission adopted additional regulations for Chemical Dependency Units on August 19, 1982. The regulations became effective, September 19, 1982. The Mississippi Department of Health took over the licensing duties of the Mississippi Health Care Commission effective July 1, 1986.

A Chemical Dependency Unit is a hospital or an established and dedicated unit of a "general", "psychiatric", or "rehabilitation" hospital, or a "freestanding" unit, which has beds that are organized, properly staffed and equipped to render services over a continuous period exceeding 24-hours to individuals requiring diagnosis and treatment of alcohol and other drug-related dependencies.

These standards are to applied in conjunction with the Minimum Standards of Operation for Mississippi Hospitals where applicable.

The standards are written so that they closely parallel the standards for accreditation of alcohol and drug abuse programs established by the Joint Commission on Accreditation of Hospitals. By basing these standards on the Joint Commission's standards, we have developed standards which have the input of a national panel of knowledgeable experts and skilled people on alcoholism and drug abuse treatment.

101 FACILITY MANAGEMENT

GOVERNING BODY

101.01 Every facility shall have a governing body that has overall responsibility for the operation of the facility.

A public facility shall have a written description of the administrative organization for the agency within which it operates.

A public facility shall also have a written description of how the lines of authority within the government agency relate to the governing body of the facility.

A private facility shall have a charter or constitution, bylaws.

101.02 The names and addresses of all owners or controlling parties of the facility (whether they are individuals; partnerships; corporate bodies; or subdivisions of other bodies, such a public agencies or religious, fraternal, or other charitable organizations) shall be fully disclosed.

In case of corporations, the names and addresses of all officers, directors, and principal stockholders either beneficial or of record shall be disclosed.

101.03 The governing body shall meet at least quarterly.

Minutes of these meetings shall be kept and shall include at least the following:

1. The date of the meeting
2. The names of members who attended
3. The topics discussed
4. The decisions reached and actions taken
5. The dates for implementation of recommendations
6. The reports of the chief executive officer and others.

101.04 The governing body shall establish a committee structure to fulfill its responsibilities and to assess the results of the facility's activities.

101.05 The governing body, through the chief executive officer, shall have a written statement of the facility's goals and objectives, as well as written procedures for implementing these goals and objectives.

There shall be documentation that the statement and procedures are based upon a planning process, and that the facility's goals and objectives are approved by the governing body.

The governing body, through the chief executive officer, shall have a written plan for obtaining financial resources that are consonant with the facility's goals and objectives.

101.06 When a categorical program (for example, a child, adolescent, or adult psychiatric, alcoholism, or drug abuse program) is a component of a larger facility, the staff of the categorical program, subject to the overall responsibility of the governing body, shall be given the authority necessary to plan, organize, and operate the program.

The categorical program shall hire and assign its own staff.

The categorical program shall employ a sufficient number of qualified and appropriately trained staff.

101.07 The governing body, through its chief executive officer, shall develop policies and shall make sufficient resources available (for example, funds, staff, equipment, supplies, and facilities) to assure that the program is capable of providing appropriate and adequate services to patients.

101.08 The facility's physical and financial resources shall be adequately insured.

Members of the governing body and appropriate administrative and professional staff should have adequate comprehensive liability insurance.

101.09 The governing body shall establish bylaws, rules and regulations, and a table of organization to guide relationships between itself and the responsible administration and professional staffs and the community.

The governing body may establish one set of bylaws, rules and regulations that clearly delineates the responsibilities and authority of the governing body and the administrative and professional staff.

Administrative and professional staffs may establish separate bylaws, rules and regulations that are consistent with policies established by the governing body.

All bylaws, rules and regulations shall comply with legal requirements, be designed to encourage high quality patient care, and be consistent with the facility's community responsibility.

Such bylaws, rules and regulations shall describe the powers and duties of the governing body and its officers and committees; or the authority and responsibilities of any person legally designed to function as the governing body, as well as the authority and responsibility delegated to the responsible administrative and professional staffs.

Such bylaws, rules and regulations shall state the eligibility criteria for governing body membership; the types of membership and the method of selecting members; frequency of governing body meetings; the number of members necessary for a quorum and other attendance requirements for governing body meetings; the requirement that meetings be documented in the form of written minutes and the duration of appointment or election for governing body members, officers, and committed chairpersons.

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form of written minutes and the duration of appointment or election for governing body members, officers, and committed chairpersons.

Such bylaws, rules and regulations shall describe the qualifications, authority, and responsibilities of the chief executive officer.

Such bylaws, rules and regulations shall specify the method for appointing the chief executive officer.

Such bylaws, rules and regulations shall provide the administrative and professional staffs with the authority and freedom necessary to carry out their responsibilities within the organizational framework of the facility.

Such bylaws, rules and regulations shall provide the professional staff with the authority necessary to encourage high quality patient care.

Such bylaws, rules and regulations shall state the procedures under which the administrative and professional staff cooperatively function.

Such bylaws, rules and regulations shall require the establishment of controls designed to encourage each member of the professional staff to observe the standards of the profession and assume and carry out functions in accordance with local, state, and federal laws and rules and regulations.

Such bylaws, rules and regulations shall require the professional staff bylaws, rules and regulations to be subject to governing body approval.

Such bylaws, rules and regulations shall specify procedures for selecting professional staff officers, directors, and department or service chiefs.

Such bylaws, rules and regulations shall require that physicians with appropriate qualifications, licenses, and clinical privileges evaluate and authenticate medical histories and physical examinations, and prescribe medications.

Such bylaws, rules and regulations may also allow dentists with appropriate qualifications, licenses, and clinical privileges to prescribe medications.

Such bylaws, rules and regulations shall describe the procedure for conferring clinical privileges on all professional staff.

Such bylaws, rules and regulations shall define the responsibilities of physicians in relation to non-physician members of the professional staff.

Such bylaws, rules and regulations shall provide a mechanism through which the administrative and professional staffs report to the governing body.

Such bylaws, rules and regulations shall define the means by which the administrative and professional staffs participate in the development of facility and program policies concerning program management and patient care.

Such bylaws, rules and regulations shall require an orientation program for new governing body members and a continuing education program for all members of the governing body.

Such bylaws, rules and regulations shall require that the bylaws, rules and regulations be reviewed at least every two years, revised as necessary, and signed and dated to indicate the time of last review.

102 CHIEF EXECUTIVE OFFICER

102.01 The governing body shall appoint a chief executive officer who shall be employed on a full-time basis.

The qualifications, authority, and duties of the chief executive officer shall be stated in the governing body's bylaws, rules and regulations.

The chief executive officer shall be a health professional with appropriate professional qualifications and experience, including previous administrative responsibility in a health facility.

The chief executive officer shall have a medical degree or at least a master's degree in administration, psychology, social work, education, or nursing; and, when required, should have appropriate licenses. Experience shall include previous administrative responsibility in a facility for children or adolescents. Experience may be substituted for a professional degree when it is carefully evaluated, justified, and documented by the governing body.

102.02 In facilities primarily serving children or adolescents, the chief executive officer shall have appropriate professional qualifications and experience, including previous administrative responsibility in a facility for children or adolescents.

102.03 In accordance with the facility's bylaws, rules and regulations, the chief executive officer shall be responsible to the governing body for the overall operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of staff.

102.04 The chief executive officer shall assist the governing body in formulating policy by preparing the following items and presenting them to and reviewing them with the governing body:

1. Long-term and short-term plans of the facility.

2. Reports on the nature and extent of funding and other available resources.

3. Reports describing the facility's operations.

4. Reports evaluating the efficiency and effectiveness of facility or program activity.

5. Budgets and financial statements.

102.05 The chief executive officer shall be responsible for the preparation of a written manual that defines the facility policies and procedures and that is regularly revised and updated.

102.06 There shall be documentation that the chief executive officer attends and participates in continuing education programs.

103 PROFESSIONAL STAFF ORGANIZATION

103.01 There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to patients, and for the ethical conduct and professional practices of its members, as well as for accounting therefore to the governing body. The manner in which the professional staff is organized shall be consistent with the facility's documented staff organization and bylaws, rules and regulations, and pertain to the setting where the facility is located. The professional staff bylaws, rules and regulations, and the rules and regulations of the governing authority shall require that a qualified physician be responsible for diagnosis and all care and treatment. The organization of the professional staff, and its bylaws, rules and regulations shall be approved by the facility's governing body.

The professional staff shall strive to assure that each member is qualified for membership and shall encourage the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic reappraisal of each staff member according to the provisions.

103.02 **Qualifications**. The appointment and reappointment of professional staff members shall be based upon well-defined, written criteria that are related to the goals and objectives of the facility as stated in the bylaws, rules and regulations of the professional staff and of the governing body.

Upon application or appointment to the professional staff, each individual must sign a statement to the effect that he or she has read and agrees to be bound by the professional staff and governing body bylaws, rules and regulations.

The initial appointment and continued professional staff membership shall be dependent upon clinical competence and ethical practice in keeping with the qualifications, standards, and requirements set forth in the professional staff and governing body bylaws, rules and regulations.

Unless otherwise provided by law, only those practitioners who are licensed, certified, or registered, or who have demonstrated competence and experience, shall be eligible for professional staff membership.

103.03 **Method of Selection**. Each facility is responsible for developing a process of appointment to the professional staff whereby it can satisfactorily determine that the person is appropriately licensed, certified, registered, or experienced, and qualified for the privileges and responsibilities he or she seeks.

103.04 **Privilege Delineation**. Privileges shall be delineated for each member of the professional staff, regardless of the type and size of the facility and the age and disability group served.

Delineation of privileges shall be based on all verified information available in the applicant's or staff member's credentials file.

Whatever method is used to delineate clinical privileges for each professional staff applicant, there must be evidence that the granting of such privileges is based on the member's demonstrated current competence.

Clinical privileges shall be facility-specific.

The professional staff shall delineate in its bylaws, rules and regulations of the qualifications, status, clinical duties, and responsibilities of clinical practitioners who are not members of the professional staff but whose services require that they be processed through the usual professional staff channels.

The training, experience, and demonstrated competence of individuals in such categories shall be sufficient to permit their performing their assigned functions.

There shall be provisions for individuals in such categories to receive professional supervision, when indicated, from their professional counterparts.

103.05 **Reappointment**. The facility's professional staff bylaws, rules and regulations shall provide for review and reappointment of each professional staff member at least once every two years.

The reappointment process should include a review of the individual's status by a designated professional staff committee, such as the credentials committee.

When indicated, the credentials committee shall require the individual to submit evidence of his or her current health status that verifies the individual's ability to discharge his or her responsibilities.

The committee's review of the clinical privileges of a staff member for reappointment should include the individual's past and current professional performance as well as his or her adherence to the governing body and professional staff bylaws, rules and regulations.

The professional staff bylaws rules and regulations shall limit the time within which the professional staff reappointment and privilege delineation processes must completed.

103.06 **Professional Staff Organization**. The professional staff shall be organized to accomplish its required functions.

The professional staff organization must provide a framework in which the staff can carry out its duties and functions effectively. The complexity of the organization shall be consistent with the size of the facility and the scope of its activities.

The professional staff bylaws, rules and regulations shall provide for the selection of officers for an executive committee and when appropriate, for other organizational components of the facility.

The professional staff bylaws, rules and regulations should specify the organization needed to provide effective governance of the professional staff.

103.07 **Executive Committee**. The executive committee shall be empowered to act for the professional staff in the intervals between the staff meetings. The committee shall serve as a liaison mechanism between the professional staff and the administration.

There shall be a mechanism that assures medical participation in the deliberations of the executive committee.

The professional staff bylaws, rules and regulations shall define the size, composition, method of selecting members, and frequency of meetings of the executive committee.

The executive committee shall maintain a permanent record of its proceedings and actions.

The functions and responsibilities of the executive committee shall include at least the following:

1. receiving and acting upon reports and recommendations from professional staff committees, departments, and services.

2. implementing the approved policies of the professional staff.

3. recommending to the governing body all matters relating to appointments and reappointments, staff categorization and assignments, clinical privileges, and except when such is a function of the professional staff or one of its committees, corrective action.

4. fulfilling the professional staff's accountability to the governing body for the quality of the overall clinical care rendered to patients in the facility; and

5. initiating and pursuing corrective action when warranted, in accordance with the provisions of the professional staff bylaws, rules and regulations.

103.08 **Professional Staff Bylaws**. The professional staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a means of accountability to the governing body. The bylaws, rules and regulations shall be subject to the approval of the governing body.

The professional staff shall regulate itself by its bylaws, rules and regulations.

The professional staff bylaws, rules and regulations shall reflect current staff practices, shall be enforced, and shall be periodically reviewed and revised as necessary.

The professional staff bylaws, rules and regulations shall include a requirement for an ethical pledge from each practitioner.

The professional staff bylaws, rules and regulations shall describe the specific role of each discipline represented on the professional staff or exercising clinical privileges in the care of patients.

The professional staff bylaws, rules and regulations shall include the following patient record requirements.

Symbols and abbreviations shall be used only when they have been approved by the professional staff and when there is an explanatory legend;

The categories of personnel who are qualified to accept and transcribe verbal orders, regardless of the mode of transmission of the orders, shall be specifically identified;

The period of time following admission to the facility within which a history and physical examination must be entered in the patient record shall be specified;

The time period in which patient records must be completed following discharge shall be specified and shall not exceed fourteen (14) days; and

The entries in patient records that must be dated and authenticated by the responsible practitioner shall be specified.

The professional staff bylaws, rules and regulations shall specify mechanisms for review, evaluation, and monitoring of professional staff practices.

The professional staff bylaws, rules and regulations shall specify mechanisms for the denial of staff appointments and reappointments, as well as for denial, curtailment, suspension, or revocation of clinical privileges.

When appropriate, this procedure shall provide for a practitioner to be heard, upon request, at some stage of the process.

104 WRITTEN PLAN FOR PROFESSIONAL SERVICES AND STAFF COMPOSITION

104.01 The facility shall formulate and specify in a written plan for professional services its goals, objectives, policies, and programs so that its performance can be measured.

The plan shall describe the services offered by the facility so that a frame of reference for judging the various aspects of the facility's operation is available.

The written plan for professional services shall describe the following:

1. the population served, including age groups and other characteristics of the patient population;

2. the hours and days the facility operates;

3. the methods used to carry out initial screening and/or triage;

4. the intake or admission process; including how the initial contact was made with the patient and the family or significant others;

5. the assessment and evaluation procedures provided by the facility;

6. the methods used to deliver services to meet the identified clinical needs of patients served;

7. the basic therapeutic programs offered by the facility;

8. the treatment planning process and the periodic review of therapy;

9. the discharge and post-therapy planning processes;

10. the organizational relationships of each of the facility's therapeutic programs, including channels of staff communication, responsibility, and authority, as well as supervisory relation-ships; and

11. the means by which the facility provides, or makes arrangements for the provision of, the following:

    a. other medical, special assessments, and therapeutic services;

b. patient education services, whether provided from within or outside the facility;

c. emergency services and crisis intervention; and

d. discharge and aftercare, including post-therapy planning and follow-up evaluation.

When the facility is organized by departments or services, the written plan for professional services shall describe how each department or service relates to the goals and other programs of the facility, specify lines of responsibility within each department or service, and define the rolls of department or service personnel and the methods for interdisciplinary collaboration.

When a facility is organized on a team or unit basis, either totally or in part, the written plan for professional services shall delineate the roles and responsibilities of team members in meeting the identified clinical needs of patients and in relation to the goals and programs of the facility.

The written plan for professional services shall be made known and available to all professional personnel and to the chief executive officer.

The plan shall be reviewed at least annually, and revised as necessary, in relation to the changing needs of the patients, the community, and the overall objectives and goals of the facility, and it shall be signed and dated by the reviewers.

104.02 Within the scope of its activities, the facility shall have enough appropriately qualified health care professional, administrative and support staff available to adequately assess and address the identified clinical needs of patients.

Appropriately qualified professional staff may include qualified child and/or adolescent psychiatrists and other physicians, clinical psychologists, social workers, psychiatric nurses, and other health care professionals in numbers and variety appropriate to the services offered by the facility and with training and experience working with children and/or adolescents.

When appropriate qualified professional staff are not available or needed on a fulltime basis, arrangements shall be made to obtain sufficient services on an attending continuing consultative, or part-time basis.

104.03 There shall be documentation to verify that health care professional staff meets all federal, state, and local requirements for licensing, registration, or certification.

104.04 **Medical Services**. A physician licensed in the State of Mississippi shall be responsible for diagnosis and all medical care and treatment. Medical services

shall be provided directly or on call 24-hours a day, 7 days a week. Upon admission there shall be written orders for the immediate care of the patient.

104.05 **Nursing Services**. Nursing services shall be under the direct supervision of a registered professional nurse who has had at least one (1) year of experience in psychiatric or mental health nursing or has had previous work experience in chemical dependency units.

The number of registered professional nurses, licensed practical nurses, and other nursing personnel shall be adequate to formulate and carry out the nursing components of the individual treatment plan for each patient.

There shall be a registered professional nurse on duty 24-hours a day, 7-days a week, to plan, assign, supervise, and evaluate nursing care, and to provide for the delivery of nursing care to patients.

104.06 **Psychiatric Services**. Patients shall be provided with psychiatric services, in accordance with their needs by a psychiatrist licensed in the State of Mississippi. Services to patients include evaluations, consultations therapy and program development.

104.07 **Psychiatric Services**. Psychiatric services are under the supervision of a clinical director, service chief or equivalent licensed physician who is qualified to provide the leadership required for an intensive treatment program.

104.08 **Psychological Services**. Patients shall be provided psychological services in accordance with their needs by a qualified psychologist.

Services to patients include evaluations, consultations, therapy and program development.

A qualified psychologist is an individual licensed by the State Board of Psychological Examiners with a specialty area in Clinical or Counseling Psychology (refer to Mississippi Code of 1972, annotated and amended, Section 73-31-1).

104.09 **Social Services**. Social work services are under the supervision of a licensed qualified social worker.

The director of the service or department shall have a master's degree from an accredited school of social work, or have been certified by the Academy of Certified Social Workers.

Social work staff shall be qualified and numerically adequate to provide the following services:

1. Psychosocial data for diagnosis and treatment planning.

2. Direct therapeutic services to individual patients, patient groups or families.

3. Develop community resources.

4. Participate in interdisciplinary conferences and meetings concerning treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

104.10 **Activity Services**. Activity service staff shall be sufficient in number and skills to meet the needs of patients and achieve the goals of the service. The activity service shall be supervised by a qualified activity director.

A qualified activity director is an individual with a bachelor's degree who has at least one-year of experience in assessing, planning, and coordinating activity services in a health care setting.

105 PERSONNEL POLICIES AND PROCEDURES

105.01 Personnel policies and procedures shall be developed in writing, adopted, and maintained to promote the objectives of the facility and to provide for an adequate number of qualified personnel during all hours of operation to support the functions of the facility and the provision of high quality care.

All personnel policies shall be reviewed and approved on an annual basis by the governing body.

There shall be documentation to verify that the written personnel policies and procedures are explained and made available to each employee.

The policies and procedures shall include a mechanism for determining that all personnel are medically and emotionally capable of performing assigned tasks and are free of communicable and infectious diseases.

105.02 There shall be written policies and procedures for handling cases of patient neglect and abuse.

The policies and procedures on patient neglect or abuse shall be given to all personnel. Any alleged violations of these policies and procedures shall be investigated, and the results of such investigation shall be reviewed and approved by the director and reported to the governing body.

105.03 A personnel record shall be kept on each staff member and shall contain the following items, as appropriate:

1. Application for employment

2. Written references and a record of verbal references

3. Verification of all training and experience, and licensure, certification, registration and/or renewals

4. Wage and salary information

5. Performance appraisals

6. Initial and subsequent health clearances

7. Disciplinary and counseling actions

8. Commendations

9. Employee incident reports

10. Record of orientation to the facility, its policies and procedures and the employee's position.

For each position in the facility, there shall be a written job description that specifies the duties and responsibilities of the position and the minimum level of education, training, and/or related work experience required or needed to fulfill it.

106 STAFF DEVELOPMENT

106.01 The facility shall have a written plan as evidence of implementation of a program of staff development and in-service training that is consistent with the basic goals and objectives of the program.

106.02 Staff development shall be under the supervision and direction of a committee or qualified person. This person or committee may delegate responsibility for any part of the program to appropriately qualified individuals.

106.03 The staff development plan shall include plans for orientation of new employees and shall specify subject areas to be covered in the orientation process.

106.04 The staff development program shall reflect all administrative and service changes in the facility and shall prepare personnel for promotions and responsibilities.

106.05 A continuous professional education program shall be provided to keep the professional staff informed of significant clinical and administrative developments and skills.

106.06 The facility shall provide continuing training for all staff and specific orientation for all new personnel in the principles of confidentiality, privacy, patients' rights, infection control, fire prevention, disaster preparedness, accident prevention and patient safety.

106.07 Specialized training shall be provided for staff working with children and adolescents.

106.08 The facility shall have documentation of the staff development, in-service training and orientation activities of all employees.

107 PATIENT RIGHTS

107.01 There shall be written policies and procedures designed to enhance the dignity of all patients and to protect their rights as human beings. These written policies and procedures shall include but not be limited to the following standards:

1. There shall be procedures to inform all patients of their legal and human rights and the rules and regulations of the facility applicable to his or her conduct. There shall be documentation of implementation of these procedures.

2. Physical restraints and seclusion shall be used only in extreme cases to protect the patient from injuring himself or others, and when all other alternatives are exhausted. They shall not be used as punishment of staff convenience.

There shall be documentation verifying that patients under physical restraint or in seclusion are observed by a staff member at least every thirty (30) minutes.

Authorization for the use of physical restraints and/or seclusion shall be written as justified in the patient's record by the attending physician. This authorization shall be renewed at least every twenty-four (24) hours.

3. The patient has the right, to the extent permitted by law, to refuse specific medications or treatment procedures. The responsibility of the facility, when the patient refuses treatment, is to seek appropriate legal alternatives or orders of involuntary treatment or, in accordance with professional standards, to terminate the relationship with the patient upon reasonable notice.

4. The risks associated with the use of any drugs and/or procedures shall be fully explained to the patient in terms that he/she can understand. The decision as to whether or not the patient is able to exercise sound judgment rests with the physician and must be documented in the patient's clinical record.

5. The patient shall give his consent in writing prior to the use of potentially hazardous drugs and procedures. In the event that the patient is unable to exercise sound judgment, the written consent of family members having the legal right to consent must be obtained prior to the use of potentially hazardous drugs and procedures. Potentially hazardous drugs and

procedures shall be administered in accordance with accepted clinical practice and shall be directed and supervised by a physician.

6. There shall be written policies and procedures for reviewing and responding to patient's communications, e.g. opinions, recommendations, and grievances, in a way that will preserve and foster conflict resolution and problem solving. The written policies shall also delineate the means by which patients are familiarized with these procedures. Each patient's personal privacy shall be assured and protected within the constraints of the individual treatment plan.

7. There shall be procedures designed to protect the patient's rights and privacy with respect to facility visitors, e.g. educational or other individual or group visitations through the program. The patients shall be informed in advance of such visitations, which shall be conducted so as to minimally interrupt the patient's usual activities and therapeutic program.

8. The facility shall provide the patient with means of communication with persons outside the program in at least the following ways, unless contraindicated by physician. Patients shall be allowed to conduct private telephone conversations with family and friends. Patients shall be allowed to send and receive unopened mail.

9. The facility shall inform the patient, the patient's family, or legal guardian as appropriate, of the cost (itemized when possible) of services rendered.

10. The facility shall assure confidential treatment of personal and Medical Records, and may approve or refuse their release to any individual outside the family, except, in case of transfer to another health care institution, or as required by law or third-party payment contract.

11. Each patient's personal dignity shall be recognized and respected in the provision of all care and treatment.

108 MEDICAL RECORDS

108.01 **Organization**. A Medical Record shall be maintained in accordance with accepted professional principles for each patient admitted for care in the facility.

108.02 Such records shall be kept confidential and only authorized personnel shall have access to the record. Staff members and other persons having access to patient records shall be required to abide by the written policies regarding confidentiality of patient records and disclosure of information in the records as well as all applicable federal, state, and local laws, rules, and regulations. Policies on confidentiality of records shall also conform to the alcohol and drug abuse confidentiality regulations as published in Part IV of the July 1, 1975 Federal Register.

108.03 The facility shall have written policies and procedures that protect the confidentiality of patient records and govern the disclosure of information in the records. The policies and procedures shall specify the conditions under which information on applicants or patients may be disclosed and the procedures for releasing such information.

108.04 A patient or his or her authorized representative may consent to the release of information provided that written consent is given on a form containing the following information:

1. name of patient
2. name of program
3. the name of the person, agency or organization to which the information is to be disclosed
4. the specific information to be disclosed
5. the purpose for the disclosure
6. the date the consent was signed and the signature of the individual witnessing the consent
7. the signature of the patient, guardian or authorized representative, and
8. a notice that the consent is valid only for a specified period of time.

108.05 The written consent of a patient, or his or her authorized representative, to the disclosure of information shall be considered valid only if the following conditions have been met:

1. the patient or the representative shall be informed, in a manner calculated to assure his or her understanding, of the specific type of information that has been requested and, if known, the benefits and disadvantages of releasing the information;
2. the patient or the representative shall give consent voluntarily;
3. the patient or the representative shall be informed that the provision of services is not contingent upon his or her decision concerning the release of information; and
4. the patient's consent shall be acquired in accordance with all applicable federal, state, and local laws, rules and regulations.

108.06 Every consent for release of information, the actual date the information was released, the specific information released, and the signature of the staff member who released the information shall be made a part of the patient record.

108.07 In a life-threatening situation or when an individual's condition or situation precludes the possibility of obtaining written consent, the facility may release pertinent medical information to the medical personnel responsible for the individual's care without the individual's consent and without the authorization of the chief executive officer or a designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the individual.

When information has been release under emergency conditions, the staff member responsible for the release of information shall enter all pertinent details of the transaction into the individual's record, including at least the following items:

1. the date the information was released;
2. the person to whom the information was released;
3. the reason the information was released;
4. the reason written consent could not be obtained; and
5. the specific information released.

The patient or applicant shall be informed that the information was released as soon as possible after the release of information.

108.08 **Medical Records** shall not be removed from the facility except upon subpoena and court order.

108.09 Preservation and Storage. Records shall be preserved, either in the original or by microfilm, for a period of time not less than that determined by the statute of limitations in the State of Mississippi.

108.10 Written Policies and Procedures shall govern the compilation, storage, dissemination, and accessibility of patient records. The policies and procedures shall be designed to assure that the facility fulfills its responsibility to safeguard and protect the patient record against loss, unauthorized alteration, or disclosure of information; to assure that each patient record contains all required information; to assure uniformity in the format and forms in use in patient records; to require entries in patient records to be dated and signed.

The facility shall provide adequate facilities for the storage, processing, and handling of patient records, including suitably locked and secured rooms and files. When a facility stores patient data on magnetic tape, computer files, or other types of automated information systems, adequate security measures shall

prevent inadvertent or unauthorized access to such data. A written policy shall govern the disposal of patient records. Methods of disposal shall be designed to assure the confidentially of information in the records.

108.11 **Personnel**. The patient records department shall maintain, control, and supervise the patient records, and shall be responsible for maintaining the quality.

108.12 A qualified medical record individual who is employed on at least a part-time basis, consistent with the needs of the facility and the professional staff, shall be responsible for the patient records department. This individual shall be a registered record administrator or an accredited record technician who has successfully completed examination requirements of the American Medical Record Association, or an individual with the documented equivalent in training and/or experience.

108.13 When it can be demonstrated that the size, location, or needs of the facility do not justify employment of a qualified individual, the facility must secure the consultative assistance of a qualified record administrator at least twice a year to assure that the patient record department is adequate to meet the needs of the facility.

108.14 **Centralization of Reports**. All clinical information pertaining to a patient's stay shall be centralized in the patient's record. The original or all reports originating in the facility shall be filed in the medical record. Appropriate patient records shall be kept on the unit where the patient is being treated and shall be directly accessible to the clinicians caring for the patient.

108.15 **Contents of Records**. The medical record shall contain sufficient information to justify the diagnosis and warrant the treatment and end results. The patient record shall describe the patient's health status at the time of admission, the services provided and the patient's progress in the facility, and the patient's health status at the time of discharge. The patient record shall provide information for the review and evaluation of the treatment provided to the patient. When appropriate, data in the patient record shall be used in training, research, evaluation, and quality assurance programs. When indicated, the patient record shall contain documentation that the rights of the patient and of the patient's family are protected. The patient record shall contain documentation of the patient's and, as appropriate, family members' involvement in the patient's treatment program. When appropriate, a separate record may need to be maintained on each family member involved in the patient's treatment program. The patient record shall contain identifying data that is recorded on standardized forms. This identifying data shall include the following:

1. full name;
2. home address;
3. home telephone number;

4. date of birth;
5. sex;
6. race or ethnic origin;
7. next of kin;
8. education;
9. marital status;
10. type and place of employment;
11. date of initial contact or admission to the facility;
12. legal status, including relevant legal documents;
13. other identifying data as indicated;
14. date the information was gathered; and
15. signature of the staff member gathering the information.

The patient record shall contain information on any unusual occurrences, such as the following:

1. treatment complications;
2. accidents or injuries to the patient;
3. morbidity;
4. death of a patient; and
5. procedures that place the patient at risk or that cause unusual pain.

As necessary, the patient record shall contain documentation of the consent of the patient, appropriate family member or guardians for admission, treatment, evaluation, aftercare, or research.

The patient record shall contain both physical and emotional diagnoses that have been made using a recognized diagnostic system.

The patient record shall contain reports of laboratory, roentgenographic, or other diagnostic procedures, and reports of medical/surgical services when performed.

The patient record shall contain correspondence concerning the patient's treatment, and signed and dated notations of telephone calls concerning the

patient's treatment. A discharge summary shall be entered in the patient's record within a reasonable period of time (not to exceed 14-days) following discharge as determined by the professional staff bylaws, rules and regulations.

The patient record shall contain a plan for aftercare.

All entries in the patient record shall be signed and dated. Symbols and abbreviations shall be used only if they have been approved by the professional staff, and only when there is an explanatory legend. Symbols and abbreviations shall not be used in the recording of diagnoses.

When a patient dies, a summation statement shall be entered in the record in the form of a discharge summary. The summation statement shall include the circumstances leading to death and shall be signed by a physician. An autopsy shall be performed whenever possible. When an autopsy is performed, a provisional anatomic diagnosis shall be recorded in the patient's record within 72 hours. The complete protocol shall be made part of the record within three months.

108.16 **Promptness of Record Completion**. Current records shall be completed promptly upon admission. Records of patients discharged shall be completed within 14 days following discharge. The staff regulations of the facility shall provide for the supervision or termination of staff privileges of physicians who are persistently delinquent in completing records.

108.17 **Identification, Filing and Indexing**. A system of identification and filing to ensure the prompt location of a patient's medical records shall be maintained.

The patient index cards shall bear at least the full name of the patient, the address, the birth date, and the medical record number.

Records shall be indexed according to disease and physician and shall be kept up to date. For indexing, any recognized system may be used.

Indexing shall be current within six months following discharge of the patient.

109 FACILITY AND PROGRAM EVALUATION

109.01 Program evaluation is a management tool primarily utilized by the facility's administration to assess and monitor, on a priority basis, a variety of facility, service, and programmatic activities.

109.02 The facility shall have a written statement of goals and objectives.

The goals and objectives shall result from a planning process.

The goals and objectives shall be related to the needs of the population served.

The written statement of the goals and objectives of the facility service and programmatic activities shall be provided to the governing body and facility administration and shall be made available to staff.

109.03 The facility shall have a written plan for evaluating its progress in attaining its goals and objectives.

The written plan shall specify the information to be collected and the methods to be used in retrieving and analyzing this information.

The written plan shall specify methods for assessing the utilization of staff and other resources to meet facility goals and objectives.

The written plan shall specify when evaluations shall be conducted.

The written plan shall specify the criteria to be used in assessing the facility's progress in attaining its goals and objectives.

The written plan shall require an explanation of any failure to achieve facility goals and objectives.

109.04 There shall be documentation that the goals and objectives of facility, service, and programmatic activities shall be evaluated at least annually and revised as necessary.

There shall be documentation that the results of the evaluation shall be provided to the governing body and facility administration and shall be made available to staff.

There shall be documentation that the findings of the evaluation have influenced facility and program planning.

110 FISCAL MANAGEMENT

110.01 The facility shall annually prepare a formal, written budget of expected revenues and expenses.

The budget shall categorize revenues for the facility by source.

The budget shall categorize expenses by the types of services of programs provided.

The budget shall be reviewed and approved by the governing body prior to the beginning of the fiscal year.

Revisions made in the budget during the fiscal year shall be reviewed and approved by the governing body.

110.02 The facility management system shall include a fee schedule.

The facility shall maintain current, written schedules of rate and charge policies that have been approved by the governing body.

The fee schedule shall be accessible to personnel and to individuals served by the facility.

INDIVIDUALIZED COMPREHENSIVE

TREATMENT PLANNING

111 INTAKE

111.01 Written policies and procedures governing the intake process shall specify the following:

1. the information to be obtained on all applicants or referrals for admission;
2. the records to be kept on all applicants;
3. the statistical data to be kept on the intake process; and
4. the procedures to be followed when an applicant or a referral is found ineligible for admission.

111.02 Criteria for determining the eligibility of individuals for admission shall be clearly stated in writing.

111.03 The intake procedure shall include an initial assessment of the patient.

The intake assessment shall be done by professional staff. The results of the intake assessment shall be clearly explained to the patient.

The results of the intake assessment shall be clearly explained to the patient's family when appropriate.

111.04 Acceptance of a patient for treatment shall be based on an intake procedure that results in the following conclusions:

1. the treatment required by the patient is appropriate to the intensity and restrictions of care provided by the facility or program component; and/or
2. the treatment required can be appropriately provided by the facility or program component; and
3. the alternatives for less intensive and restrictive treatment are not available.

111.05 During the intake process, every effort shall be made to assure that applicants understand the following:

1. the nature and goals of the treatment programs;

2. the treatment costs to be borne by the patient, if any; and

3. the rights and responsibilities of patients, including the rules governing patient conduct and the types of infractions that can result in disciplinary action or discharge from the facility or program component.

111.06 Facilities shall have policies and procedures that adequately address the following items for each patient:

1. responsibility for medical and dental care, including consents for medical or surgical care and treatment;

2. when appropriate, arrangements for family participation in the treatment program;

3. arrangements for clothing, allowances, and gifts;

4. arrangements regarding the patient's departure from the facility or program; and

5. arrangements regarding the patient's departure from the facility or program against clinical advice.

111.07 When a patient is admitted on court order, the rights and responsibilities of the patient and the patient's family shall be explained to them.

111.08 Sufficient information shall be collected during the intake process to develop a preliminary treatment plan.

111.09 Staff members who will be working with the patient but who did not participate in the initial assessment shall be informed about the patient prior to meeting him or her.

112 ASSESSMENTS

112.01 Within 72 hours of admission, the staff shall conduct a complete assessment of each patient's needs. The assessment shall include, but shall not necessarily be limited to, physical, emotional, behavioral, social, recreational, and nutritional needs.

112.02 A licensed physician shall be responsible for assessing each patient's physical health. The health assessment shall include a medical, alcohol and drug history; a physical examination; neurological examination when indicated and a laboratory workup. The physical examination shall be completed, within 24 hours after admission.

112.03 In facilities serving children and adolescents, each patient's physical health assessment shall also include evaluations of the following: motor development and functioning; sensorimotor functioning; speech, hearing, and language functioning; visual functioning; and immunization status. Facilities serving children and adolescents shall have all necessary diagnostic tools and personnel available to perform physical health assessments.

112.04 A registered nurse shall be responsible for obtaining a nursing history and assessment at the time of admission.

112.05 An emotional and behavioral assessment of each patient shall be completed and entered in the patient's record. The assessment shall include, but not be limited to, the following items:

1. a history of previous emotional and behavioral functioning;
2. the patient's current emotional and behavioral functioning;
3. when indicated, a direct psychiatric evaluation; and
4. when indicated, psychological assessments, including intellectual and personality testing.

112.06 A social assessment of each patient shall be completed by the qualified social worker and entered in the patient's record. The assessment shall include information relating to the following areas, as necessary:

1. environment and home;
2. religion;
3. childhood history;
4. military service history;
5. financial status;
6. the social, peer-group, and environment setting from which the patient comes; and
7. the patient's family circumstances, including the constellation of the family group, the current living situation; and social, ethnic, cultural, emotional, and health factors, including drug and alcohol use.

112.07 When appropriate, an activities assessment of each patient shall be completed by the qualified activity director and shall include information relating to the individual's current skills, talents, aptitudes, and interest.

112.08 A nutritional assessment shall be conducted by the food service supervisor or registered dietitian and shall be documented in the patient's record.

113 TREATMENT PLANS

113.01 Each patient shall have a written individual treatment plan that is based on assessments of his or her clinical needs.

113.02 Overall development and implementation of the treatment plan shall be assigned to an appropriate member of the professional staff.

113.03 The treatment plan shall be developed as soon as possible after the patient's admission.

113.04 Appropriate therapeutic efforts may begin before a fully developed treatment plan is finalized.

113.05 Upon admission, a prelimary treatment plan shall be formulated on the basis of the intake assessment.

113.06 Within 72 hours following admission a designated member of the treatment team shall develop an initial treatment plan that is based on at least an assessment of the patient's presenting problems, physical health, emotional status, and behavioral status. This initial treatment plan shall be utilized to implement immediate treatment objectives.

If a patient's stay in a facility is ten days or less, only a discharge summary will be required in addition to be initial treatment plan.

If a patient's stay in a facility exceeds ten days, the interdisciplinary team shall develop a master treatment plan that is based on a comprehensive assessment of the patient's needs.

The master treatment plan shall contain objectives and methods for achieving them.

113.07 The treatment plan shall reflect the facility's philosophy of treatment and the participation of staff from appropriate disciplines.

113.08 The treatment plan shall reflect consideration of the patient's clinical needs.

113.09 The treatment plan shall specify the services necessary to meet the patient's needs.

113.10 The treatment plan shall include referrals for needed services that are not provided directly by the facility.

113.11 The treatment plan shall contain specific goals that the patient must achieve to attain, maintain, and/or reestablish emotional and/or physical health as well as maximum growth and adaptive capabilities. These goals shall be based on assessments of the patient and, as appropriate, the patient's family.

113.12 The treatment plan shall contain specific objectives that related to the goals, are written in measureable terms, and include expected achievements dates.

113.13 The treatment plan shall describe the services, activities, and programs planned for the patient, and shall specify the staff members assigned to work with the patient.

113.14 The treatment plan shall specify the frequency of treatment procedures.

113.15 The treatment plan shall delineate the specific criteria to be met for termination of treatment. Such criteria shall be a part of the initial treatment plan.

113.16 When appropriate, the patient shall participate in the development of his or her treatment plan, and such participation shall be documented in the patient's record.

113.17 A specific plan for involving the family or significant others shall be included in the treatment plan when indicated.

114 PROGRESS NOTES

114.01 Progress notes shall be recorded by the physician, nurse, social worker and, when appropriate, others significantly involved in treatment. The frequency of progress notes is determined by the condition of the patient but should be recorded at least weekly for the first two (2) months and at least monthly thereafter.

114.02 Progress notes shall be entered in the patient's record and shall include the following:

1. documentation of implementation of the treatment plan;

2. documentation of all treatment rendered to the patient;

3. description of change in the patient's condition; and

4. descriptions of the response of the patient to treatment, the outcome of treatment, and the response of significant others to important intercurrent events.

114.03 Progress notes shall be dated and signed by the individual making the entry.

114.04 All entries involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed.

115 TREATMENT PLAN REVIEW

115.01 Interdisciplinary case conferences shall be regularly conducted to review and evaluate each patient's treatment plan and his or her progress in attaining the stated treatment goals and objectives.

115.02 Interdisciplinary case conferences shall be documented, and the results of the review and evaluation shall be recorded in the patient's record. The review and update shall be completed no later than thirty (30) days following the first 10-days of treatment and at least every sixty (60) days thereafter.

116 DISCHARGE PLANNING/AFTERCARE

116.01 The facility maintains a centralized coordinated program to ensure that each patient has a planned program of continuing care which meets his post discharge needs.

116.02 Each patient shall have an individualized discharge plan which reflects input from all disciplines involved in his care. The patient, patient's family, and/or significant others shall be involved in the discharge planning process.

116.03 Discharge planning data shall be collected at the time of admission or within seven (7) days thereafter.

The chief executive officer shall delegate the responsibility for discharge planning, in writing, to one or more staff members.

116.04 The facility shall maintain written discharge planning policies and procedures which describe:

1. how the discharge coordinator will function, and his authority and relationships with the facility's staff;

2. the time period in which each patient's need for discharge planning is determined (within seven days after admission);

3. the maximum time period after which reevaluation of each patient's discharge plan is made;

4. local resources available to the facility and the patient to assist in developing and implementing individual discharge plans; and

5. provisions for periodic review and reevaluation of the facility's discharge planning program (at least annually).

116.05 An interdisciplinary case conference shall be held prior to the patient's discharge. The discharge/aftercare plan shall be reviewed with the patient, patient's family and/or significant others.

116.06 The facility shall have documentation that the aftercare plan has been implemented and shall have documentation of follow-ups to assure referrals to appropriate community agencies.

117 DISCHARGE SUMMARY

117.01 A discharge summary shall be entered in the patient's record within fourteen (14) days following discharge. The discharge summary shall include but not be limited to:

1. reason for admission;
2. brief summary of treatment;
3. reason for discharge;
4. assessment of treatment plan goals and objectives; and
5. recommendations and arrangements for further treatment, including prescribed medications and aftercare.

SUPPORT SERVICES

118 PHARMACY

118.01 **Direction and Supervision**. The hospital shall have a pharmacy directed by a registered pharmacist, who has had, by education or experience, training in the specialized area of hospital pharmacy. The pharmacy or drug room shall be administered in accordance with accepted professional principles. The pharmacist shall be assisted, as needed, by additional qualified pharmacists and ancillary personnel. Pharmacy assistants shall work under the supervision of a pharmacist and shall not be assigned duties that are required to be performed only by registered pharmacists.

Provision shall be made for emergency pharmaceutical services.

118.02 **Records**. Records shall be kept of the transactions of the pharmacy (or drug room) and correlated with other hospital records where indicated. Such special records shall be kept as required by law. The pharmacy shall establish and maintain a satisfactory system of records and accountability in accordance with the policies of the hospital for maintaining adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies.

A record of the stock on hand and of the dispensing of all narcotic drugs shall be maintained in such a manner that the disposition of any particular item may be readily traced.

The label of each outpatient's individual prescription medication container shall bear the lot and control number of the drug, the name of the manufacturer (or trademark) and, unless the physician directs otherwise, the name of the medication dispensed.

118.03 **Control of Toxic or Dangerous Drugs. Policies** shall be established to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage. The facility shall establish a written policy that all toxic or dangerous medications, not specifically prescribed as to time or number of doses, shall be automatically stopped after a reasonable time limit. The classification ordinarily thought of as toxic, dangerous or abuse drugs shall be narcotics, sedatives, anticoagulants, antibiotics, oxytocics and cortisone products, and shall include other categories so established by federal, state or local laws.

118.04 **Drugs to be Dispensed**. The pharmacist, with the advice and guidance or the pharmacy and therapeutics committee, shall be responsible for specifications as to quality, quantity, and source of supply of all drugs.

There shall be available a formulary or list of drugs accepted for use in the facility which is developed and amended at regular intervals by the pharmacy and therapeutics committee (or equivalent committee) with the cooperation of the pharmacist and the administration.

The pharmacy or drug room shall be adequately supplied with preparations as approved.

118.05 **Committee**. There shall be a pharmacy and therapeutics committee (or equivalent committee) composed of physicians and pharmacists, and registered professional nurses established in the facility.

It shall represent the organizational line of communication and the liaison between the professional staff and the pharmacist.

The committee shall assist in the formulation of board professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, and safety procedures, and all other matters relating to drugs in hospitals.

The committee shall perform the following specific functions:

1. serve as an advisory group to the professional staff and the pharmacist on matters pertaining to the choice of drugs;

2. develop and review periodically a formulary or drug list for use in the facility;

3. establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs;

4. evaluate clinical data concerning new drugs or preparations requested for use in the facility;

5. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services; and

6. prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

The committee shall meet at least quarterly and report to the professional staff.

118.06 **Medication Control**. The facility shall have written policies and procedures designed to ensure that all medications are dispensed and administered safely and properly in accordance with the applicable federal, state, and local laws and regulations.

Medication orders shall be written only by authorized prescribers.

An up-to-date list of authorized prescribers shall be available in all areas where medication is dispensed.

Telephone orders shall be accepted only from individuals on the list of authorized prescribers.

Telephone orders shall be limited to emergency situations that have been defined in writing in the facility's policies and procedures manual.

Telephone orders shall be accepted and written in the patient's record only by staff authorized to administer medication.

Telephone orders shall be signed by an authorized prescriber on the next regular working day, but in all events within 72 hours.

A written order signed by the authorized prescriber shall be included in patient's record.

Medication orders that contain abbreviations and chemical symbols shall be carried out only if the abbreviations and symbols are on a standard list approved by the physician members of the professional staff.

There shall be automatic stop orders on specified medications. Refer to 118.03.

There shall be a specific routine of drug administration, indicating dose schedules and standardization of abbreviations.

Only pharmacists, physicians, registered nurses, or licensed practical nurses shall administer medications.

Self-administration of medication shall be permitted only when specifically ordered by the responsible physician.

Drugs brought into the facility by patients shall not be administered unless they can be absolutely identified, and unless written orders to administer these specific drugs are given by the responsible physician. If the drugs that the patient brings to the facility are not to be used, they shall be packaged, sealed, and stored, and, if approved by the responsible physician, they shall be returned to the patient, family, or significant others at the time of discharge.

The patient and, when appropriate, the family shall be instructed about which medications if any, are to be administered at home.

Medications administered, medication errors, and adverse drug reactions shall be documented in the patient's record.

Facilities should implement a reporting system under which the reporting program of the federal Food and Drug Administration and the drug manufacturer are advised of unexpected adverse drug reactions.

There shall be methods of detecting drug side effects of toxic reactions.

Investigational drugs shall be used only under the direct supervision of the principal investigator and with the approval of research review committee and either the physician members of the professional staff or an appropriate committee of the professional staff.

A central unit shall be established where essential information on investigational drugs, such as dosage form, dosage range, storage requirements, adverse reactions, usage, and contraindications, is maintained.

Investigational drugs shall be properly labeled.

Nurses may administer investigational drugs only after receiving basic pharmacologic information about the drugs.

The facility shall have specific methods for controlling and accounting for drug products.

The pharmacy service shall maintain records of its transactions as required by law and as necessary to maintain adequate control of, and accountability for, all drugs.

These records shall document all supplies issued to units, departments, or services of the facility, as well as all prescription drugs dispensed.

Records and inventories of the drugs listed in the current Comprehensive Drug Abuse Prevention and Control Act shall be maintained as required by the act and regulations.

Distribution and administration of controlled drugs are adequately documented, and inspections of these records by the pharmacist is documented.

118.07 **Emergency Medication Kit**. There is an emergency kit that is:

1. made up under the supervision and responsibility of the pharmacist, and is approved by the Pharmacy and Therapeutic Committee;

2. readily available to staff yet not accessible to patients;

3. constituted so as to be appropriate to the needs of the patients; and

4. inspected monthly to remove deteriorated and outdated drugs and to ensure completeness of content.

The pharmacist responsible for the emergency kit shall provide a list of its contents and appropriate instructions, and shall authenticate this list with his signature.

118.08 **Storage of Drugs**. Drug storage shall be maintained in accordance with the security requirements of federal, state, and local laws. Drugs preparation areas and drug storage area shall be well-lighted and shall be so located that personnel will not be interrupted when handling drugs. All drugs shall be kept in locked storage.

Poisons, external drugs, and internal drugs shall be stored on separate shelves or in separate cabinets.

Medications that are stored in a refrigerator containing items other than drugs shall be kept in a separate compartment or container with proper security.

Antidote charts and the telephone number of the regional poison control center shall be kept in all drug storage and preparation areas.

118.09 **Space for Storage of Drugs**. Adequate space shall be provided in the Pharmacy for storage of drugs and for keeping of necessary records. The pharmacy shall be capable of being securely locked in accordance with regulations regarding storage of dangerous drugs. Adequate space is defined on a minimum of 250 sq. ft. for 50 beds or less; 500 sq. ft. of storage for 75 beds or less; 750 sq. ft. for 100 beds or less; and 1000 sq. ft. for 100 beds or more.

118.10 **Quality Assurance Activities**. A pharmacist shall regularly review the medication records of patients.

All medication orders shall be reviewed monthly by the responsible physician. Adverse drug reactions and medication errors shall be reported to the physician responsible for the patient, and shall be documented in the patient's record.

The pharmacist in charge of dispensing medications, shall provide for monthly inspection of all storage units, including emergency boxes and emergency carts.

A record of these inspections shall be maintained in order to verify the following:

Disinfectants and drugs for external use are stored separately from internal and injectable medications.

Drugs requiring special conditions for storage to ensure stability are properly stored.

118.11 **Continuing Education**. The director of the pharmacy service shall receive orientation in the specialized functions of the facility.

A pharmacist should participate in staff development programs for the clinical staff.

As appropriate, a pharmacist should participate in drug abuse education programs conducted by the facility.

As appropriate, a pharmacist should participate in public education and information programs relative to the services of the facility.

Up-to-date pharmaceutical reference material shall be provided so that appropriate staff will have adequate information concerning drugs.

Current editions of text and reference books covering the following topics shall be provided: theoretical and practical pharmacy; general, organic, pharmaceutical, and biological chemistry; toxicology; pharmacology; bacteriology; sterilization and disinfection; and other subjects important to good patient card.

118.12 **Functional Safety and Sanitation**. Adequate precautions shall be taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

All drugs shall be kept in locked storage.

Security shall be maintained in accordance with local and state laws.

Poisons, external drugs, and internal drugs shall be stored on separate shelves or in separate containers.

Drug preparation and storage areas shall be well-lighted and shall be located where personnel will not be interrupted when handling drugs.

Metric-apothecaries' weight and measure conversion charts shall be posted in each drug preparation area and wherever else they are needed.

119 DIETARY

119.01 **Organization**. The facility shall have an organized dietary department directed by a qualified food service supervisor, with services of a registered dietitian on at least a consultant basis. However, a facility which has a contract with an outside food management company may be found to meet this requirement if the company has a therapeutic dietitian who serves, as required by scope and complexity of the services, on a full-time, part-time, or consultant basis to the facility.

1. The qualified dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration.

2. When a qualified dietitian is employed on a part-time or consultative basis, the dietitian shall devote enough time to accomplish the following tasks:

    a. Assure continuity of services;

    b. Direct the nutritional aspects of patient care;

    c. Assure that dietetic instructions are carried out;

    d. On occasion, supervise the serving of meals; and

    e. Assist in the evaluation of the dietetic services.

3. Regular written reports shall be submitted to the chief executive officer on the extent of services provided by the dietitian.

4. There shall be written policies and procedures for food storage, preparation, and service developed by a registered dietitian.

5. The dietetic service shall have an adequate number of appropriately qualified individuals to meet the dietetic needs of the facility's patients.

6. Written job descriptions of all dietary employees shall be available.

7. There shall be procedures to control dietary employees with infectious and open lesions. Routine health examinations shall meet local and state codes for food service personnel.

8. There shall be an on-going planned in-service training program for dietary employees which includes the proper handling of food and personal grooming, safety, sanitation, behavioral and therapeutic needs of patients.

119.02 **Facilities**. Adequate space, equipment, ventilation and supplies as well as any necessary written procedure and precautions, shall be provided for the safe and sanitary operation of the dietetic service and the safe and sanitary handling and distribution of food.

1. The food service area should be appropriately located.

2. The dietitian's office should be easily accessible to all who require consultation services.

3. Sufficient space shall be provided for support personnel to perform their duties.

4. The layout of the department and the type amount, size, and placement of equipment shall make possible the efficient preparation and distribution of food.

5. Lavatories with wrist action blades, soap dispenser and disposable towel dispenser shall be located throughout the dietary department.

6. Dry or staple food items shall be stored in a ventilation room which is not subject to sewage or waste water back flow, or contamination by condensation, leakage, rodents or vermin.

7. All perishable foods shall be refrigerated at the appropriate temperature and in an orderly and sanitary manner. Each refrigerator shall contain a thermometer in good working order.

8. Foods being displayed or transported shall be protected from contamination.

9. Dishwashing procedures and techniques shall be developed and carried out in compliance with the state and local health codes.

10. All garbage and kitchen refuse which is not disposed of mechanically shall be kept in leak-proof non-absorbent containers with close fitting covers and be disposed of routinely in a manner that will not permit transmission of disease, a nuisance, or a breeding place for files. All garbage containers are to be thoroughly cleaned inside and outside each time emptied.

11. All dietary areas, equipment, walls, floors, etc., shall be kept maintained in good working condition and sanitary at all times.

119.03 **Diets**. There shall be systematic record of diets, correlated when appropriate, with the medical records. The dietitian shall have available an up-to-date manual of regimens for all therapeutic diets, approved jointly by the dietitian and medical staff, which is available to dietary supervisory personnel. Diets serve to patients shall be in compliance with these established diet principles.

1. The diet manual shall be reviewed annually and revised as necessary by a qualified dietitian, and shall be dated to identify the time of the review.

2. Revisions to the diet manual shall be approved by the facility's physician.

3. The diet manual should be used to standardize the ordering of diets.

4. The policies and procedures shall provide for dietetic counseling.

5. The nutritional deficiencies of any diet in the manual shall be indicated.

6. The policies and procedures shall require the recording of dietetic orders in the patient's record.

7. The policies and procedures shall require the recording of all observations and information pertinent of dietetic treatment in the patient's record by the food service supervisor or dietitian.

8. The policies and procedures shall require the use of standards for nutritional care in evaluating the nutritional adequacy of the patient's diet and in ordering diet supplements. The current Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences is suggested as a guide in developing these standards.

9. The policies and procedures shall describe the methods for assuring that each patient on a special diet receives the prescribed diet regimen.

10. The policies and procedures shall provide for altering diets or diet schedules as well as for discontinuing diets.

11. Dietetic service personnel shall conduct periodic food acceptance studies among the patients and should encourage them to participate in menu planning.

12. The results of food acceptance studies should be reflected in revised menus.

13. All menus shall be approved by a qualified dietitian.

119.04 **Food Service and Dining**. Food shall be served in an appetizing and attractive manner, at planned and realistic mealtimes, and in a congenial and relaxed atmosphere.

1. Dining areas should be attractive and maintained at appropriate temperatures.

2. The dietetic services shall be patient-oriented and should take into account the many factors that contribute to the wide variations in patient eating habits, including cultural, religious, and ethnic factors.

3. Snacks shall be available as appropriate to the nutritional needs of the patients and the needs of the facility.

4. The dietetic service shall be prepared to give extra food to individual patients.

5. Appropriate food should be available for patients with special or limited dietary needs.

6. There shall be adequate equipment provided for tray assembly and tray delivery.

7. Facilities or arrangements shall be available for family and friends to eat with patients when possible.

120 ACTIVITY SERVICES

120.01 The facility shall provide, or make arrangements for the provision of activity services to all patients in accordance with their needs and interests and as appropriate within the scope of the facility's program.

120.02 The facility shall have a written plan that describes the organization of their activity services or the arrangements made for the provision of activity services. The activity services shall have a well-organized plan for using community resources. The goals and objectives of the facility's activity services shall be stated in writing.

120.03 The facility shall have written policies and procedures for the activity services which are made available to activity services and other appropriate personnel. The policies and procedures shall be reviewed and revised at least annually.

120.04 Appropriate activities shall be provided to all patients during the day, in the evening, and on weekends. The daily activities program shall be planned to provide a consistent and well-structured yet flexible framework for daily living. Whenever possible, patients should participate in planning activity services.

120.05 Activity schedules shall be posted in places accessible to patients and staff.

120.06 The activities program shall be reviewed and revised according to the changing needs of patients.

120.07 When indicated, activity services shall be incorporated in the patient's treatment plan. Activity services that are included in a patient's treatment plan shall reflect an assessment of the patient's needs, interests, life experiences, capacities, and deficiencies. Activity services staff shall collaborate with other professional staff in delineating goals for patients' treatment, health maintenance, and vocational adjustments.

120.08 The patient's record shall contain progress notes that describe the patient's response to activity services and other pertinent observations.

120.09 There shall be documentation that patients are given leisure time and that they are encouraged to use their leisure time in a way that fulfills their cultural and recreational interests and their feelings of human dignity.

120.10 Vehicles used for transportation shall not be labeled in a manner that calls unnecessary attention to the patients.

120.11 **Quality Assurance Activities**. The activity service shall have written procedures for ongoing review and revision of its goals, objectives, and role within the family.

The activity service shall maintain statistical and other records on the functioning and utilization of the services.

120.12 **Continuing Education**. The facility shall maintain ongoing staff development programs.

Activity service staff shall participate in appropriate clinical and administrative committees and conferences.

Activity service staff shall receive training and demonstrate competence in handling medical and psychiatric emergencies.

The activity service shall encourage extramural studies and evaluations of activity services and extramural research in activity services.

120.13 **Functional Safety and Sanitation**. Appropriate space, equipment, and facilities shall be provided to meet the needs of patients for activity services:

1. Facilities and equipment designated for activity services shall be constructed or modified in such a manner as to provide, insofar as possible, pleasant and functional areas that are accessible to all patients regardless of their disabilities.

2. Space for offices, storage, and supplies shall be adequate and accessible.

3. When indicated, equipment and supplies that enable the activity to be brought to the patient should be used.

4. Space, equipment and facilities utilized both inside and outside the facility shall meet federal, state, and local requirements for safe fire prevention, health and sanitation.

121 REFERRALS

121.01 The facility shall have written policies and procedures that facilitate the referral of patients and the provision of consultation between the facility's program components and between the facility and other service providers in the community.

121.02 The written policies and procedures shall describe the methods by which continuity of care is assured for the patient. These methods shall include, but not be limited to, providing the facility, program component, or other service provider to which the patient is referred with the following:

1. background information on the referral;

2. information on the patient's treatment, for example, current treatment, diagnostic assessments, and special requirements;

3. treatment objectives desired;

4. suggestions for continued coordination between the referring and the receiving resource;

5. special clinical management requirements; and

6. information on how the patient can be returned to the referring facility or program component.

121.03 The referring facility shall ask the receiving facility, program component, or other service provider to which the patient is referred, to submit a follow-up report within a designated time period.

121.04 The written policies and procedures shall describe the mechanism by which a patient may be referred.

121.05 The written policies and procedures shall describe the means by which the facility assists in the referral of individuals who are seeking services that the facility does not provide.

121.06 The written policies and procedures shall be reviewed and approved annually by the director and appropriate administrative and professional staff members. The annual review and approval shall be documented.

121.07 Each community service provider to which patients are referred shall express in writing its willingness to abide by federal and state standards concerning confidentiality of patient information.

121.08 The facility shall have a letter of agreement and/or contract with community service providers that it uses repeatedly.

122 LABORATORY AND RADIOLOGIC SERVICES

122.01 The facility shall have provisions for promptly obtaining required laboratory, x-ray, and other diagnostic services.

122.02 If the facility provides its own laboratory and x-ray services, these shall meet the applicable standards established for hospital censure. Refer to Part III, Chapter 6, Section 627, and Part VI, Chapters 19 and 2102.3.

122.03 If the facility itself does not provide such services, arrangements shall be made for obtaining these services from a licensed and certified laboratory.

122.04 All laboratory and x-ray services shall be provided only on the orders of the attending physician.

122.05 The facility shall assist the patient, if necessary, in arranging for transportation to and from the source of service.

122.06 All signed and dated reports of laboratory, x-ray, and other diagnostic services shall be filed with the patient's medical record.

123 LIBRARY SERVICES

123.01 Library services shall be made available to meet the professional and technical needs of the facility's staff.

Facilities that do not maintain a professional library shall have an arrangement with a nearby facility or institution to use its professional library.

Current reference material, books, and basic health care journals shall be available in each facility.

The library service shall establish regular and convenient hours of service so that staff may have prompt access to current materials.

When a facility operates its own library, the professional library service shall provide pertinent, current and useful medical, psychiatric, psychological, alcohol, drug, educational, and related materials. A facility providing extensive library services should utilize the services of a professional librarian.

124 EMERGENCY SERVICES

124.01 The facility shall have written procedures for taking care of emergencies. Emergency services shall be provided by the facility or through clearly defined arrangements with another facility.

124.02 When emergency services are provided by an outside facility, a written plan shall delineate the type of emergency services available and the arrangements for referring or transferring patients to another facility. The written plan shall be available to all professional staff and shall clearly specify the following:

1. The staff of the facility who are available and authorized to provide necessary emergency evaluations;

2. The staff of the facility who are authorized to arrange for patients to be referred or transferred to another facility when necessary;

3. The arrangements the facility has made for exchanging records with the outside facility when it is necessary for the care of the patient;

4. The location of the outside facility and the names of the appropriate personnel to contact;

5. The method of communication between the two facilities;

6. The arrangements the facility has made to assure that when a patient requiring emergency care is transferred to a non-psychiatric or substance abuse service or facility, he or she will receive further evaluation and/or treatment of his or her psychiatric or substance abuse program, as needed;

7. The arrangements the facility has made for transporting patients, when necessary, from the facility to the facility providing emergency services;

8. The policy for referring patients needing continued care after emergency services back to the referring facility; and

9. Policies concerning notification of the patient's family of emergencies and of arrangements that have been made for referring or transferring that patient to another facility.

124.03 When an emergency service is provided by the facility, the service shall be well organized, properly directed, and integrated with other services of the facility and shall comply with Part IV, Chapter 7, Section 701-705.6.

PHYSICAL PLANT MANAGEMENT

125 INFECTION CONTROL

125.01 Because infections acquired in a facility or brought into a facility from the community are potential hazards for all persons having contact with the facility, there shall be an infection control program.

Effective measures shall be developed to prevent, identify and control infections.

125.02 Written policies and procedures pertaining to the operation of the infection control program shall be established, reviewed at least annually, and revised as necessary.

125.03 A practical system shall be developed for reporting, evaluating, and maintaining records of infections among patients and personnel. This system shall include assignment of responsibility for the ongoing collection and analysis of data, as well as for the implementation of required follow-up action. Corrective action taken on the basis of records and reports of infections and infection potentials among patients and personnel shall be documented.

125.04 All new employees shall be instructed in the importance of infection control and personal hygiene, and in their responsibility in the infection control program. There shall be documentation that inservice education-in infection prevention and control is provided to employees in all services and program components.

126 REGULATED MEDICAL WASTE

126.01 "Infectious medical wastes" includes solid or liquid wastes which may contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host has been proven to result in an infectious disease. For purposes of this Regulation, the following wastes shall be considered to be infectious medical wastes:

1. Wastes resulting from the care of patients and animals who have Class I and (or) II diseases that are transmitted by blood and body fluid as defined in the rules and regulations governing reportable diseases. (See attached) as defined by the Mississippi Department of Health;

2. Cultures and stocks of infectious agents; including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

3. Blood and blood products such as serum, plasma, and other blood components;

4. Pathological wastes, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

5. Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in medical research;

6. All discarded sharps (e.g., hypodermic needles, syringes, Pasteur pipettes, broken glass, scalpel blades) which have come into contact with infectious agents;

7. Other wastes determined infectious by the generator or so classified by the MS Department of Health.

`Medical Waste' means all waste generated in direct patient care or in diagnostic or research areas that is non-infectious but aesthetically repugnant if found in the environment."

126.02 **Medical Waste Management Plan**. All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following:

Storage and Containment of Infectious Medical Waste and Medical Waste

1. Containment of infectious medical waste and medical waste shall be in a manner and location which affords protection from animals, rain and wind, does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to the public.

2. Infectious medical waste shall be segregated from other waste at the point of origin in the producing facility.

3. Unless approved by the Mississippi Department of Health or treated and rendered non-infectious. Infectious medical waste (except for sharps in approved containers) shall not be stored at a waste producing facility for more than seven days above a temperature of 6 C (38F). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of O C (32F) for a period of not more than 90 days without specific approval of the Department of Health.

4. Containment of infectious medical waste shall be separate from other wastes. Enclosures or containers used for containment of infectious medical waste shall be so secured so as to discourage access by unauthorized persons and shall be marked with prominent warning sings on, or adjacent to, the exterior of entry doors, gates, or lids. Each container shall be prominently labeled with a sign using language to be determined by the Department and legible during daylight hours.

5. Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have a strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid wasted during storage, handling, or transport.

6. All sharps shall be contained for disposal in leak-proof, rigid, puncture resistant containers which are taped closed or tightly lidded to preclude loss of the contents.

7. All bags used for containment and disposal of infectious medical waste shall be of a distinctive color or display the Universal Symbol for infectious waste. Rigid containers of all sharps waste shall be labeled.

8. Compactors or grinders shall not be used to process infectious medical waste unless the waste has been rendered non-infectious. Sharps containers shall not be subject to compaction by any compacting device except in the institution itself and shall not be placed for storage or transport in a portable or mobile trash compactor.

9. Infectious medical waste and medical waste contained in disposable containers as prescribed above, shall be placed for storage, handling, or transport in disposable or reusable pails, cartons, drums, or portable bins. The containment system shall be leak-proof, have tight-fitting covers and be kept clean and in good repair.

10. Reusable containers for infectious medical waste and medical waste shall be thoroughly washed and decontaminated each time they are emptied by a method specified by the Mississippi Department of Health, unless the surfaces of the containers have been protected from contamination by disposable liners, bags, or other devices removed with the waste, as outlined in I.E.

Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures:

a. Exposure to hot water at least 180 F for a minimum of 15 seconds.

b. Exposure to a chemical sanitizer by rinsing with or immersion in one of the following for a minimum of 3 minutes:

i. Hypochlorite solution (500 ppm available chlorine).

ii. Phenolic solution (500 ppm active agent).

iii. Iodoform solution (100 ppm available iodine).

iv. Quaternary ammonium solution (400 ppm active agent).

Reusable pails, drums, or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as noninfectious waste or for other purposes except after being decontaminated by procedures as described in part (10) of this section.

11. Trash chutes shall not be used to transfer infectious medical waste.

12. Once treated and rendered non-infectious, previously defined infectious medical waste will be classified as medical waste and may be land-filled in an approved landfill.

Treatment or disposal of infectious medical waste shall be by one of the following methods:

1. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.

2. By sterilization by heating in a steam sterilizer, so as to render the waste non-infectious. Infectious medical waste so rendered non-infectious shall be disposable as medical waste. Operating procedures for steam sterilizers shall include, but not be limited to, the following:

    a. Adoption of standard written operating procedures for each steam sterilizer including time, temperature, pressure, type of waste, type of container(s), closure on container(s), pattern of loading, water content, and maximum load quantity.

    b. Check or recording and/or indicating thermometers during each complete cycle to ensure the attainment of a temperature of 121 C (250 F) for one-half hour or longer, depending on quantity and density of the load, in order to achieve sterilization of the entire load. Thermometers shall be checked for calibration at least annually.

    c. Use of heat sensitive tape or other device for each container that is processed to indicate the attainment of adequate sterilization conditions.

    d. Use of the biological indicator Bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least monthly to confirm the attainment of adequate sterilization conditions.

    e. Maintenance of records of procedures specified in (a), (b), (c) and (d) above for period of not less than a year.

3. By discharge to the approved sewerage system if the waste is liquid or semi-liquid, except as prohibited by the MS Department of Health.

4. Recognizable human anatomical remains shall be disposed of by incineration or internment, unless burial at an approved landfill is specifically authorized by the Mississippi Department of Health.

5. Chemical sterilization shall use only those chemical sterilants recognized by the U.S. Environmental Protection Agency, Office of Pesticides and Toxic Substances. Ethylene oxide, glutaraldehyde, and hydrogen peroxide are examples of sterilants that, used in accordance with manufacturer recommendation, will render infectious waste noninfectious. Testing with Bacillus subtilis spores or other equivalent organisms shall be conducted quarterly to ensure the sterilization effectiveness of gas or steam treatment.

Treatment and disposal of medical waste which is not infectious shall be by one of the following methods:

1. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.

2. By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land, and which is not a treatment facility.

All the requirements of these standards shall apply, without regard to the quantity of medical waste generated per month, to any generator of medical waste.

127 THERAPEUTIC ENVIRONMENT

127.01 The facility shall establish an environment that enhances the positive self-image of the patient and preserves human dignity.

Patients shall be allowed to wear their own clothing.

Patients shall be allowed to keep and display personal belongings and to add personal touches to the decoration of their own room.

Articles for grooming and personal hygiene shall be readily available for the individual patient in a space reserved adjacent to his sleeping area.

All areas and surfaces shall be free of undesirable odors.

There shall be ample closet and drawer space for the storage of personal property provided for the patient's use.

Program personnel shall respect the patient's right to privacy by knocking on the door of the patient's room before entering.

A laundry room in which a patient may wash his own clothing shall be accessible.

The services of a barber and a beautician shall be made available at the patient's request.

Staff areas should be open to promote patient-personnel interaction.

Patients shall be encouraged to take responsibility for maintaining their own living quarters. Such responsibilities shall be clearly defines in writing and provided to the patient at orientation.

127.02 The environment shall contribute to the development of therapeutic relationships in at least the following ways.

1. Areas shall be available for a range of social activities for all patients.

2. Attractively furnished areas shall be available where a patient can be alone, when this would not be in conflict with a therapeutic prescription for group activities.

3. Attractively furnished areas shall be provided to ensure privacy for conversations with other patients, family, or friends.

127.03 The environments shall be designed to allow views of the outdoors.

127.04 To promote awareness of the time and season, clocks and calendars should be provided at least in the major use areas.

127.05 There shall be documentation of planned programs, consistent with the needs of the patients, for social, educational and recreational activities for all patients for daytime, evenings, and weekends.

127.06 The facility shall assure accessibility for handicapped individuals, preferably through its physical environment, or as an alternative, through a written plan that indicates how the patient or potential patient shall receive necessary services.

127.07 The environment shall be maintained and equipped so as to ensure the health safety of the patients. Physical health and safety features of the environment shall conform to requirements of local, state, and federal authorities having jurisdiction. In any event, the facility shall provide verification of the following:

1. patients shall be protected against the dangers of fire and smoke.

2. patients shall be protected against injury attributable to the design and equipment of the environment.

3. patients shall be protected against electrical hazards.

4. patients shall be protected against spread of disease and infection.

128 PHYSICAL PLANT CONSTRUCTION REFERENCES

128.01 The following minimum standards as stated in previous parts are also applicable to chemical dependency units: Refer to Part III, Chapter 6 - Physical Plant

601 General

601.1 Facilities for adolescents and children shall be provided separate from adult facilities for living, dining and program purposes.

602 Codes

603 Submission of Plans

603.1

603.2

603.3

603.4

603.5

603.6

603.7

604 Environment

605 Zoning Restrictions

606 Access

607 Elements of Construction

Add

Corridors - shall be 60" wide and 7'6" high (clear). The surface of all floors and walls shall be washable. All corridors longer than 150' shall be subdivided by a smoke barrier and must be maintained free of obstruction.

607.2 Change to read:

Doors-all doors in corridors shall be 20-minutes fire rated doors (1-3/4" solid core wood door as a minimum). All doors to patient bedrooms, diagnostic and treatment areas, and other doors used by residents shall be at least 36" wide. No door shall swing into the corridor except closet doors. Doors to hazardous areas defined in the Life Safety Code shall be 1-1/2 hour "B" labeled fire doors. Exit doors shall conform to the requirements set forth in the Life Safety code.

608 Fire Reporting and Protection

608.1

608.2

609 Heating and Ventilating

610 Plumbing

610.1

610.2

610.3

611 Sewage Disposal

611.1

611.2

612.2 Change to read:

Nurses' Call System: A minimum of 10% of the facility bedrooms be equipped with a nurses' call system. The rooms that are equipped with nurses' call system shall be located adjacent to the nurses' station.

These rooms are generally intended for initial detoxification or special treatment.

613 Emergency Electrical Services

613.1

613.2

613.3 Change to read:

Emergency Electrical Systems: Emergency electrical service shall be provided in accordance with the applicable section of the Life Safety Code.

614 Patient Rooms

614.1

614.2

614.3

614.4

614.5 Change to read:

Furnishings:

a. Bed-each patient room shall be equipped with a quality bed acceptable for this environment.

b. Bedside Cabinet-A bedside cabinet or table shall be provided.

614.6

614.7 Delete (Cubicle Curtains)

614.8

614.9

614.10 Change to read:

614.11 A lavatory shall be located in the bedroom or in a private toilet room.

615 Service Areas

616 Delete (Isolation Room)

617 Detention Room

618 Delete (Special Care)

619 Delete (Newborn Nursery)

621 Delete (Pediatric Unit)

622

623 Delete (Central Sterile Supply)

625 Change to read:

Outpatient Area: An outpatient area shall be provided when indicated.

626 Radiology Suite (Delete if provided by arrangement)

627 Laboratory (Delete if provided by arrangement)

628 Drug Room-Refer to Section 2501.9-Pharmacy Services

629 Dietary

630 Administrative Area

631 Change to read:

Housekeeping Area-to include:

a. Housekeeper's office or suitable area designated for record keeping.

b. Storage space for maid's carts, if used.

632 Laundry

Add:

632.1 Facilities shall be provided for personal laundry for use by patients. This area shall be separated from areas by a one hour fire rated wall.

633 Change to read:

General Storage: There shall be a two hour fire rated lockable room large enough to provide five square feet of general storage for each bed provided.

634 Boiler Room

635 Change to read:

Maintenance Area: Sufficient area for performing routine maintenance activities shall be provided and shall include an office or suitable area designated for record keeping.

Add the following sections:

638 Day Room: At least two general areas for use as living room, day room or recreation shall be provided. A minimum of 18 square feet per patient bed shall be available for this purpose.

639 Dining Room: A minimum of 15 square feet per patient bed shall be provided for use as a Dining Room. Adequate tables and chairs shall be provided to seat all patients, staff and guests.

640 Counseling Rooms: At least one, small room shall be provided for each 20 patients for the purpose of individual private treatment or counseling.

641 Examination & Treatment Room: At least one room shall be provided for the purpose of examination and treatment. The room shall be equipped with a lavatory and towel dispenser, examination table and storage space, with adequate lighting.

642 Group Counseling Rooms: At least two rooms shall be provided large enough to accommodate 8-10 patients for the purpose of group counseling sessions.

1401 Fire Control and Internal Disaster

1501 Housekeeping

1502

1503 Delete

1503.1

1504

1504.1

1504.2

1504.3

1504.4

1601-1606 Laundry and Linen

129 GLOSSARY

129.01 **Activity Director, Qualified**. An individual with a bachelor's degree who has at least one year of experience in assessing, planning, and coordinating activity services.

129.02 **Activity Services**. Structured activities designed to develop an individuals creative, physical, and social skills through participation in recreational, art, dance, drama, social, and other activities.

129.03 **Administrative**. Relates to the fiscal and general management of a facility rather than to the direct provision of services to patients.

129.04 **Aftercare**. Services that are provided to a patient after discharge and that support and increase the gains made during treatment.

129.05 **Assessment**. Those procedures by which a person evaluates an individual's strengths, weaknesses, problems and needs.

129.06 **Authentication**. Proof of authority and responsibility by written signature, identifiable initials, computer key, or other method. The use of a rubber stamp signature is acceptable only under the following conditions: the person whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it, and this person gives the chief executive officer a signed statement that he or she is the only one who has the stamp and is the only one who will use it.

129.07 **Authority Having Jurisdiction**. The organization, office, or individual responsible for approving a piece of equipment, an installation, or a procedure.

129.08 **Bylaw**s. The laws, rules, or regulations adopted for the government of the facility. Also used for the laws, rules, or regulations of the professional staff.

129.09 **Chemical Dependency Unit**. A hospital or an established and dedicated unit of a "general", "psychiatric" or "rehabilitation" hospital, or a "free-standing" unit, which has beds that are organized, properly staffed and equipped to render services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment of alcohol and other drug-related dependencies.

129.10 **Chief Executive Officer**. A job-descriptive term used to identify the individual appointed by the governing body to act on its behalf in the overall management of the facility. Other job titles may include administrator, superintendent, director, president, vice-president, and executive vice-president.

129.11 **Clinical Privileges**. Authorization of the governing body to render patient care and treatment services in the facility within well-defined limits, based upon the individual's professional qualifications, experience, competence, ability, and judgment.

129.12 **Consultant**. An individual who provides professional advice or services upon request.

129.13 **Contract**. A formal agreement with any organization, agency, or individual, approved by the governing body, that specifies the services, personnel, and/or space to be provided to, or on behalf of, the facility and the monies to be expended in exchange.

129.14 **Counselor**. An individual with specialized training.

129.15 **Department**. A staff entity organized on administrative, functional, or disciplinary lines.

129.16 **Detoxification**. The systematic reduction of the amount of a toxic agent in the body or the elimination of a toxic agent from the body.

129.17 **Dietetic Services**. The provision of services to meet the nutritional needs of patients, with specific emphasis on patients who have special dietary needs, for example, patients who are allergic to certain foods or who cannot accept a regular diet.

129.18 **Dietitian, Qualified**. An individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association.

129.19 **Diet Manual**. An up-to-date, organized system for standardizing the ordering of diets.

129.20 **Discharge**. The point at which the patient's active involvement with a facility is terminated and the facility no longer maintains active responsibility for the patient.

129.21 **Drug History**. A delineation of the drugs used by a patient, including prescribed and unprescribed drugs and alcohol. A drug history includes, but is not necessarily limited to, the following: drugs used in the past; drugs used recently, especially within the preceding 48 hours; drugs of preference; frequency with which each drug is used; route of administration of each drug; drugs used in combination; dosages used; year of first use of each drug; previous occurrences of overdose, withdrawal, or adverse drug reactions; and history or previous treatment received for alcohol or drug abuse.

129.22 **Emergency Kit**. A kit designed to provide the medical supplies and pharmaceutical agents required during an emergency. In compiling emergency kits, staff should consider the patients' needs for psychotropic, anticholinergic, and adrenalin agents.

129.23 **External Disaster**. A catastrophe that occurs outside the facility and for which the facility, based on its size, and resources must be prepared to serve the community.

129.24 **Facility**. An organization that provides psychiatric substance abuse, and/or mental health services to patients.

129.25 **Fiscal Management**. Procedures used to control a facility's overall financial and general operations. Such procedures may include cost accounting, program budgeting, materials purchasing, and patient billing.

129.26 **Formulary**. A catalog of the pharmaceuticals approved for use in a facility. A formulary lists the names of the drugs and information regarding dosage, contraindications, and unit dispensing size.

129.27 **Goal**. An expected result or condition that takes time to achieve, that is specified in a statement of relatively broad scope, and that provides guidance in establishing intermediate objectives directed towards its attainment.

129.28 **Governing Body**. The person or person with ultimate authority and responsibility for the overall operation of the facility.

129.29 **Guardian**. A parent, trustee, committee, conservator, or other person or agency empowered by law to act on behalf of, or have responsibility for, an applicant or patient.

129.30 **Hazardous Area**. Any area in which the following are used: products that are highly combustible, highly flammable, or explosive; or materials that are likely to burn with extreme rapidity or produce poisonous fumes or gases. Consult the 1972 edition of the Life Safety Code (NFPA 101) for further clarification.

129.31 **Hazardous Procedures**. Procedures that place the patient at physical or psychological risk or in pain.

129.32 **Incident Reports**. Documentation of events or actions that are likely to lead to adverse effects and/or that vary from established policies and procedures pertaining to patient care.

129.33 **Interdisciplinary Team**. A group of clinical staff composed of representative from different professions, disciplines, or service areas.

129.34 **May**. Used to reflect an acceptable method of compliance with a standard that is recognized but not preferred. See shall and should.

129.35 **Medical Record Administrator, Qualified**. A registered record administrator who has successfully passed an appropriate examination conducted by the American Medical Record Association.

129.36 **Medical Record Technician, Qualified**. An accredited record technician who has successfully passed the appropriate accreditation examination conducted by the American Medical Record Association.

129.37 **NFPA**. National Fire Protection Association, 470 Atlantic Avenue, Boston, Massachusetts 02210.

129.38 **Nurse**. A person licensed and registered to practice nursing in the state in which he or she practices.

129.39 **Nurse, Practical**. A person licensed or registered as a practical or vocational nurse in the state in which he or she practices.

129.40 **Objective**. An unexpected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement, and is related to the attainment of a goal.

129.41 **Occupational Therapist, Qualified**. An individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body, or who currently holds certification by the American Occupational Therapy Association as an occupational therapist, registered, who meets any current legal requirements of licensure or registration; and who is currently competent in the field.

129.42 **Parenteral Product**. Sterile, pharmaceutical preparations ingested by the body through a route other than the alimentary canal.

129.43 **Patient**. An individual who receives treatment services. Patient is synonymous with client, resident, consumer, and recipient of treatment services.

129.44 **Personnel Record**. The complete employment record of a staff member or an employee, including job application, education and employment history, performance evaluation, and, when applicable, evidence of current licensure, certification, or registration.

129.45 **Pharmacist**. An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and chemicals in the state in which he or she practices.

129.46 **Physician, Qualified**. A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in the state in which he or she practices.

129.47 **Program**. A general term for an organized system of services designed to address the treatment needs of patients.

129.48 **Program Evaluation**. An assessment component of a facility that determines the degree to which a program is meeting its stated goals and objectives.

129.49 **Psychiatrist, Qualified**. A doctor of medicine who specializes in the assessment and treatment of individuals having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices.

129.50 **Psychologist, Qualified**. An individual licensed by the State Board of Psychological Examiners with a specialty area in clinical or counseling psychology (refer to Mississippi Code of 1972, annotated and amended. Section 73-31-1)

129.51 **Restraint**. A physical or mechanical device used to restrict the movement of the whole or a portion of a patient's body. This does not include mechanisms used to assist a patient in obtaining and maintaining normative body functioning, for example, braces and wheelchairs.

129.52 **Seclusion**. A procedure that isolates the patient to a specific environmental area removed from the patient community.

129.53 **Service**. Used to indicate a functional division of a program or of the professional staff. Also used to indicate the delivery of care.

129.54 **Shall**. Used to indicate a mandatory standard.

129.55 **Should**. Used in a standard to indicate the commonly accepted method of compliance.

129.56 **Social Assessment**. The process of evaluating each patient's environment, religious background, childhood developmental history, financial status, reasons for seeking treatment , and other pertinent information that may contribute to the development of the individualized treatment plan.

129.57 **Social Worker, Qualified**. An individual who is licensed in the State with a master's degree from an institution accredited by the Council on Social Work Education, and is clinically qualified by training with two years experience in working with mentally ill children/adolescents.

129.58 **Substance Abuse Worker**. Professionals representing multiple disciplines who have clinical training and/or experience specifically related to providing substance abuse services.

129.59 **Therapeutic Activity Services**. Goal-oriented activities designed to help an individual develop expressive and/or performance skills through participation in art, crafts, dance, drama, movement, music, prevocational, recreational, self-care, and social activities.

129.60 **Transfer**. Movement of a patient from one treatment service or location to another.